



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
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October 14, 2009

Russell McCoy
Rulon House
415 South Arthur
Pocatello, ID 83204

RE: Rulon House, provider #13G020

Dear Mr. McCoy:

This is to advise you of the findings of the Medicaid/Licensure survey of Rulon House, which was conducted on October 8, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **October 27, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by October 27, 2009. If a request for informal dispute resolution is received after October 27, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

RECEIVED

October 26, 2009

OCT 28 2009

FACILITY STANDARDS

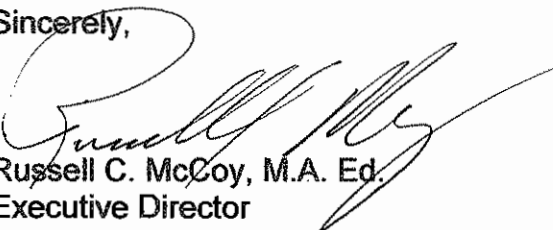
Ms. Nicole Wisenor, Supervisor
Non-Long Term Care
Department of Health and Welfare
Division of Medicaid
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Rulon House Group Home from the survey completed October 8, 2009. On the Statement of Deficiencies / Plan of Correction, Form HCFA-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed below.

Sincerely,



Russell C. McCoy, M.A. Ed.
Executive Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2009
NAME OF PROVIDER OR SUPPLIER RULON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey. The surveyor conducting the survey was: Monica Williams, QMRP Common abbreviations used in this report are: ATS - Active Treatment Specialist IDT - Interdisciplinary Team IPP - Individual Program Plan QMRP - Qualified Mental Retardation Professional	W 000		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on review of the facility's investigations and staff interviews, it was determined the facility failed to ensure a significant event was promptly reported to the legal guardian for 1 of 1 individual (Individual #8) reviewed who was involved in an abuse investigation. This resulted in the potential lack of advocacy for an individual by his guardian. The findings include: 1. An investigation, dated 7/14/09, showed that on 7/13/09, a direct care staff pushed Individual #8 so he would sit down and called him a "little (expletive)." The investigation showed the allegation was substantiated and the staff person was released from employment.	W 148	W148 483.420(c)(6) The Residential Program Director will review all forms the facility uses for investigations as well as the standard operating procedure to ensure that the client's parents or guardian are notified promptly. "Promptly" will be defined in the SOP as well. Corrective Action Completion Date: November 30, 2009 Person Responsible: Jamie L. Anthony, Residential Program Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 148	Continued From page 1 The investigation showed the incident was not reported to Individual #8's guardian until 7/15/09 at 3:45 p.m. When asked, the Program Director stated during an interview on 10/8/09 from 8:00 - 9:10 a.m., she could not find documented evidence of prior attempts to notify Individual #8's guardian of the incident. The facility failed to ensure Individual #8's guardian was promptly notified of physical and verbal abuse.	W 148			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure data was collected in the frequencies specified in the plans of 3 of 4 individuals (Individuals #1 - #3) whose QMRP summaries were reviewed. Failure to document data consistently had the potential to impede the ability of the IDT in evaluating the effectiveness of programmatic techniques. The findings include: 1. Individual #2's IPP, dated 1/6/09, documented a 48 year old female diagnosed with moderate mental retardation. Individual #2's QMRP summaries, dated 1/09 -	W 252	W252 483.440(e)(1) The Active Treatment Specialist or Qualified Mental Retardation Professional will be required to count all data by the 15 th of the month and identify any problem areas related to obtaining sufficient data for the month. This information will be given to both the Residential Program Director (for tracking purposes) as well as the Support Trainers (for correction). This will correct the current program of missing data and prevent the problem from recurring in the future. Corrective Action Completion Date: November 30, 2009 Person Responsible: Jamie L. Anthony, Residential Program Director; Ryan Shelton, Qualified Mental Retardation Professional; Josh Woolstenhulme, Active Treatment Specialist		

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W 252	<p>Continued From page 2</p> <p>8/09, showed data was missing on programs, identified below. When asked about the missing data, the ATS and QMRP both stated during an interview on 10/8/09 from 8:00 - 9:10 a.m., staff were implementing programs but were not consistently collecting data.</p> <p>a. Her IPP contained an objective to put her change in a jar or lock box at least eight trials per month. Her QMRP summaries showed data was collected at the following rates: 5/09: 2 trials. 6/09: 4 trials. 8/09: 6 trials.</p> <p>b. Her IPP contained an objective to complete the first step of a three step direction at least eight trials per month. Her QMRP summaries showed data was collected at the following rates: 1/09: 0 trials. 2/09: 0 trials. 3/09: 0 trials.</p> <p>c. Her IPP contained an objective to ask staff how many minutes to cook food in the microwave at least eight trials per month. Her QMRP summaries showed data was collected at the following rates: 2/09: 2 trials. 4/09: 0 trials.</p> <p>d. Her IPP contained an objective to go to the bathroom for self administration of medications at least eight trials per month. Her QMRP summaries showed data was collected at the following rates: 1/09: 5 trials. 3/09: 0 trials.</p>	W 252			

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W 252	<p>Continued From page 3</p> <p>e. Her IPP contained an objective to access the community at least 20 times a month. Her QMRP summaries showed data was collected at the following rates: 4/09: 11 times. 6/09: 12 times. 7/09: 16 times.</p> <p>f. Her IPP contained an objective to exercise at least 5 times a week (or 20 times a month). Her QMRP summaries showed data was collected at the following rates: 3/09: 13 times 5/09: 16 times. 6/09: 15 times.</p> <p>g. Her IPP contained an objective to participate in gum stimulation each day. Her QMRP summaries showed data was collected at the following rates: 3/09: 13 times 4/09: 22 times. 5/09: 16 times. 7/09: 18 times. 8/09: 24 times.</p> <p>h. Her IPP contained an objective to participate in memory and cognitive activities each day. Her QMRP summaries showed data was collected at the following rates: 3/09: 24 times 4/09: 26 times. 5/09: 27 times.</p> <p>2. Individual #3's IPP, dated 12/2/08, documented a 45 year old male diagnosed with severe mental retardation, Down's syndrome, and dementia.</p> <p>Individual #3's QMRP summaries, dated 1/09 -</p>	W 252			

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W 252	<p>Continued From page 4</p> <p>8/09, showed data was missing on programs, identified below. When asked about the missing data, the ATS and QMRP both stated during an interview on 10/8/09 from 8:00 - 9:10 a.m., staff were implementing programs but were not consistently collecting data.</p> <p>a. His IPP contained a service objective to offer him 5 to 6 prunes or prune juice, in addition to breakfast, each day in order to provide extra fiber. His QMRP summaries showed data was collected at the following rates: 3/09: 18 days of data. 4/09: 12 days of data. 5/09: 17 days of data. 6/09: 13 days of data. 7/09: 7 days of data. 8/09: 21 days of data.</p> <p>b. His 12/2/08 IPP contained an objective to participate in sensory and cognitive activities at least twice a day, each month. His QMRP summaries showed data was collected at the following rates: 1/09: 25 2/09: 29 3/09: 27 4/09: 12 5/09: 38 6/09: 30 7/09: 27 8/09: 36</p> <p>3. Individual #1's IPP, dated 1/20/09, documented a 46 year old male diagnosed with profound mental retardation and autism.</p> <p>Individual #1's QMRP summaries, dated 1/09 - 8/09, showed data was missing on his money</p>	W 252			

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W 252	Continued From page 5 management program, identified below. When asked about the missing data, the ATS and QMRP both stated during an interview on 10/8/09 from 8:00 - 9:10 a.m., staff were implementing programs but were not consistently collecting data. His IPP contained an objective to pick an item to purchase at least eight trials per month. His QMRP summaries showed data was collected at the following rates: 2/09: 0 trials. 5/09: 4 trials. 6/09: 4 trials. 8/09: 4 trials. The facility failed to ensure data was collected at the required frequency for Individual #1 - Individual #3.	W 252			
W 256	483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure IPPs were revised as appropriate for 1 of 4 individuals (Individual #1) whose IPPs and program summaries were reviewed. This resulted in a consistent regression of an individual's skills without appropriate programmatic revisions being made. The findings include:	W 256	W256 483.440(f)(1)(ii) The Qualified Mental Retardation Professional will revise any programs in which the client fails to make progress for three months. The Residential Program Director will ensure the correct program revisions are implemented into the current group books at the home. The Qualified Mental Retardation Professional will need to submit any program revisions to the Residential Program Director each month for implementation. The Residential Program Director will review the Q-Sums for Rulon Group Home every three months to ensure program revisions are being considered at the appropriate times.		

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W 256	<p>Continued From page 6</p> <p>1. Individual #1's IPP, dated 1/20/09, documented a 46 year old male diagnosed with profound mental retardation and autism.</p> <p>Individual #1's QMRP summaries, dated 1/09 - 8/09, showed the following objectives with a lack of consistent progress and no revisions were completed.</p> <p>a. The objective for dressing was set at 70% a month for 3 consecutive months. His QMRP summaries, dated 1/09 - 8/09, showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/09: 62% - 2/09: 15% - 3/09: 3% - 4/09: 0% - 5/09: 16% - 6/09: 0% - 7/09: 0% - 8/09: 0%; revised <p>Individual #1 failed to show consistent or sustained progress since 1/09, and no revisions were made to address the issue until August.</p> <p>b. The objective for grooming was set at 10% a month for 3 consecutive months. His QMRP summaries, dated 1/09 - 8/09, showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/09: 0% - 2/09: 0% - 3/09: 0% - 4/09: 0% - 5/09: 11% - 6/09: 0%; revised task sheet. - 7/09: 0% - 8/09: 0%; revised task sheet "still not in book." <p>Individual #1 failed to show consistent or sustained progress since 1/09, and the 6/09</p>	W 256	<p>Corrective Action Completion Date: November 30, 2009</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director and Ryan Shelton, Qualified Mental Retardation Professional</p>		

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W 256	<p>Continued From page 7</p> <p>revision had not been implemented to address the issue as of August.</p> <p>c. The objective for purchasing was set at 40% a month for 4 consecutive months. His QMRP summaries, dated 1/09 - 8/09, showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/09: 25% - 2/09: 9% - 3/09: 0% - 4/09: 0% - 5/09: 0% - 6/09: 0%; revised task sheet. - 7/09: 100% - 8/09: 0%; revised task sheet "still not in book." <p>Individual #1 failed to show consistent or sustained progress since 1/09, and the 6/09 revision had not been implemented to address the issue as of August.</p> <p>d. The objective for toileting was set at 30% a month for 2 consecutive months. His QMRP summaries, dated 1/09 - 8/09, showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/09: 0% - 2/09: 9% - 3/09: 32% - 4/09: 0% - 5/09: 0% - 6/09: 2% - 7/09: 23% - 8/09: 20% <p>Individual #1 failed to show consistent or sustained progress since 1/09, and no revisions were made to address the issue.</p> <p>e. The objective for bathing was set at 10% a month for 2 consecutive months. His QMRP summaries, dated 1/09 - 8/09, showed the</p>	W 256			

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W 256	<p>Continued From page 8</p> <p>following status of the objective:</p> <ul style="list-style-type: none"> - 1/09: 0% - 2/09: 9% - 3/09: 0% - 4/09: 0% - 5/09: 13% - 6/09: 9% - 7/09: 0%; revised task sheet. - 8/09: 0%; "waiting for new (task) sheet." <p>Individual #1 failed to show consistent or sustained progress since 1/09, and the 6/09 revision had not been implemented to address the issue as of August.</p> <p>f. The objective for self administration of medication was set at 10% a month for 5 consecutive months. His QMRP summaries, dated 1/09 - 8/09, showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/09: 46% - 2/09: 20% - 3/09: 22% - 4/09: 0% - 5/09: 0% - 6/09: 12%; revised task sheet. - 7/09: 0%; new task sheet "not in book yet." - 8/09: 0% new task sheet in book. <p>Individual #1 failed to show consistent or sustained progress since 1/09, and the 6/09 revision had not been implemented to address the issue until August.</p> <p>g. The objective for hand washing was set at 15% a month for 3 consecutive months. His QMRP summaries, dated 1/09 - 8/09, showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/09: 0% - 2/09: 3% - 3/09: 0% 	W 256			

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W 256	<p>Continued From page 9</p> <ul style="list-style-type: none"> - 4/09: 0% - 5/09: 0% - 6/09: 0%; revised task sheet. - 7/09: 0%; new task "should be in Aug (August) data." - 8/09: 0% <p>Individual #1 failed to show consistent or sustained progress since 1/09, and no revisions were made to address the issue until at least July.</p> <p>h. The objective for oral desensitization was set at 90% a month for 5 consecutive months. His QMRP summaries, dated 11/08 - 8/09, showed the following status of the objective:</p> <ul style="list-style-type: none"> - 11/08: 97% - 12/08: 96% - 1/09: 96% - 2/09: 48% - 3/09: 75% - 4/09: 74% - 5/09: 91% - 6/09: 50% - 7/09: 41% - 8/09: 47% <p>Individual #1 failed to show consistent or sustained progress since 1/09, and no revisions were made to address the issue.</p> <p>When asked about the data, the QMRP stated during an interview on 10/8/09 from 8:00 - 9:10 a.m., revisions were not made because of Individual #1's autism.</p> <p>The facility failed to ensure programmatic revisions were made in a timely manner for Individual #1.</p>	W 256			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2009
NAME OF PROVIDER OR SUPPLIER RULON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W252.	MM212	MM212 16.03.11.075.17(a) Please refer to W212 RECEIVED OCT 28 2009 FACILITY STANDARDS	
MM231	16.03.11.080.03(a) Informed of Activities To be informed of activities related to the resident that may be of interest to them or of significant changes in the resident's condition; and This Rule is not met as evidenced by: Refer to W148.	MM231	MM231 16.03.11.080.03(a) Please refer to W148	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: During an environmental survey conducted on	MM380	MM380 16.03.11.120.03(a) The oven drawer containing food debris and grease spills has been cleaned The kick plate of the refrigerator containing food debris and spills has been cleaned The window blind in the living room will be replaced The floor vent in the men's restroom containing rust will be replaced The caulking between the base of the bathtub and the linoleum in the women's restroom will be replaced.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Executive Director*
STATE FORM 8899 RZPH11

TITLE

(X6) DATE

10/26/09

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2009
NAME OF PROVIDER OR SUPPLIER RULON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
MM380	Continued From page 1 10/7/09 from 4:15 - 5:15 p.m., the following concerns were noted: - The oven drawer contained food debris and grease spills. - The kick plate of the refrigerator contained food debris and spills. - The window blind in the living room contained several broken slats. - The floor vent in the men's restroom contained rust. There was a build-up of brown matter around the base of the toilet. - There was no caulking between the base of the bathtub and the linoleum in the women's restroom. The baseboard behind the door was missing. - A ceiling tile in the laundry room contained a 4 inch hole.	MM380	The baseboard behind the door will be replaced. A ceiling tile in the laundry room will be replaced. To ensure that these problems to recur, the Weekly Home Inspection will be revised to include the areas of concern listed above. Corrective Action Completion Date: November 30, 2009 Person Responsible: Sam Guyette, Physical Facilities Manager and Jamie L. Anthony, Residential Program Director MM861 16.03.11.270.08(f)(iii) Please refer to W256		
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W256.	MM861			